2012 Open Enrollment Frequently Asked Questions

General

Q1. **Are all employees required to go online?**

A. No, just employees who wish to make a change to their current enrollment or enroll/re-enroll in a spending account. If no changes are made by November 15, 2011, your current Medical, Delta Dental, Vision, Group Legal and Disability plan elections will remain unchanged. To continue participating in either the Dependent Care or Health Care Flexible Spending Accounts, you must re-enroll.

Q2. **Who is an eligible dependent?**

A. You may cover your Spouse\Domestic Partner and dependent children under your medical, dental, and vision plans. The limiting age for dependent children is the end of the calendar year that the child reaches age 26 for medical, age 25 for dental and vision. Medical coverage only may be extended to age 30, under the conditions listed below. For additional information, click the Eligible Dependents link in the Benefits Menu.

Dependent Children Age 26+ to 30 (Florida statute (FSS 627.6562)
Medical coverage may be continued for adult children age 26+ through the end of the calendar year the child turns 30, if the child:

1. Is not married, has no dependents (i.e. children, spouse\domestic partner), and
2. Is not provided or otherwise have available other major medical health insurance, and
3. Is either a resident of Florida or a student in another state.

This provision applies only to the medical plans, not dental or vision. Premiums will be deducted post-tax. The limiting age for dental and vision coverage is age 25 (end of calendar year). Coverage may be extended for disabled dependent children if proof of disability is provided to and accepted by the plan.

To enroll a new dependent age 26+ to 29 (not currently enrolled in a County medical plan) proof of other continuous creditable coverage (without a gap of more than 63 days), must be submitted to the health plan. Adult children who reach age 30 before January 1, 2012 are not eligible for coverage.

Q3. **What number do I call if I encounter technical difficulties?**

A. You must contact the ETSD Help Desk at (305) 596-HELP.

Q4. **Who do I contact if I need assistance submitting a change online?**

A. Please contact your departmental personnel representative (DPR).

Q5. **Are new hires eligible to participate in the 2012 online open enrollment?**

A. All new employees must enroll for benefits directly online, through the County's eNet portal New Hire Benefits Enrollment link. Only new employees meeting the benefits eligibility criteria can access the enrollment website. To access the website, go to http://enet.miamidade.gov then select the New Hire Benefits Enrollment link.

New Hires with a benefits eligibility date of October 1, 2011 or earlier will enroll for their initial benefits through the online New Hire Benefits Enrollment link, but must use the online Open Enrollment website (also on eNet) to re-enroll for a spending account or to modify their plan election for 2012. New hires with a benefits eligibility

date of November 1 or December 1, 2011 cannot enroll on the Open Enrollment website. You must submit your benefits selections online through the New Hire Benefits Enrollment link. Your 2011 new hire plan selections will carry over into 2012. If enrolling in a spending account you will be required to select two (2) annual contribution amounts; one for the balance of 2011 and a separate amount for the 2012 plan year.

Q6. **May I make a change to one benefit without changing my other coverages?**

A. Yes. Each plan selection is independent of the other. Spending account enrollees must submit a new election if they wish to continue a spending account for 2012.

Q7. **May I enroll dependents in a plan without enrolling myself?**

A. No. You must be enrolled in order to select coverage for your dependent(s).

Q8. **What is the deadline for completing the online enrollment?**

A. The deadline to submit changes for the 2012 plan year is November 15, 2011.

Q9. **If after submitting my online change, I realize an error was made, may I update?**

A. Yes, as long as the deadline of November 15, 2011 has not passed. The request with the most current date will be processed and considered final.

Q10. **Will I be able to make a change after the open enrollment deadline has passed?**

A. Only changes resulting from processing errors will be allowed after the deadline has passed. However, the Benefits Open Enrollment web site will not be available to make changes; you must contact your DPR. Processing errors are defined as the unlikely event of a computer system malfunction that failed to process the employee's elections, as recorded on the final Online Benefits Confirmation Summary.

Q11. **What is the deadline to report processing errors?**

A. Processing errors must be reported to your DPR as soon as possible but no later than January 20, 2012. A processing error is defined as a computer system malfunction that failed to process the employee's elections, as recorded on the final confirmation notice submission. Forgetting to add a dependent or change benefit options is not considered a processing error.

Q12. **When will changes become effective?**

A. Benefits, other than those requiring evidence of insurability (basic life, STD and LTD), are effective January 1, 2012. Basic life STD and LTD benefits are effective upon approval of the medical evidence of insurability by MetLife.

Q13. **Will I receive a confirmation of my 2012 benefit selections?**

A. Yes. You will be able to view and print the 2012 Online Benefits Confirmation Summary after benefit selections are saved and submitted successfully.

Medical

Q14. **What medical plans will the County offer in 2012?**

A. The following plans will be offered:

AvMed Point of Service (POS)
AvMed High Option HMO
AvMed Low Option HMO

Q15. **If I am adding eligible dependents or changing providers, and my dependents have a different last name, where do I mail documentation establishing dependent eligibility?**

A. Legal documentation such as marriage certificates, birth certificates, legal guardianship papers, Affidavit of Eligibility etc. must be forwarded to your Department Personnel Representative for transmittal to the health plans. The documentation must be received by the health plan no later than by December 1, 2011. Please include your name and social security number on the documentation and retain proof of any mailing or fax sent. If you wish, you may submit directly to the health plan as follows:

AvMed
Onsite Service Representative
SPCC- 111 NW 1 Street, Suite 2340
Miami, Fl 33128
Phone: (305)375-5306
Fax (305)372-6097

Q16. **What is required if I am enrolling an unmarried dependent child over the age of 19 but under 27 years?**

A. No documentation will be required for dependents age 19 to 26 (turning 26 in 2012), unless the new dependent has a different last name than the employee's. Proof of financial dependency, residency or student status are no longer required for this group.

Q17. **Am I required to select a primary care physician (PCP) and if so, how do I obtain a list of participating providers?**

A. You are required to select a PCP only if enrolling in the AvMed Low Option HMO. A different PCP may be selected for each enrolled dependent. A list of participating providers is available by selecting the plan provider's link included on the online menu.

Q18. **May my unmarried dependent child be covered beyond the age of 25?**

A. Please see response to question above "Has there been any change in the dependent eligibility rules?" Disabled dependent children must be enrolled in the plan prior to age 25 for benefits to continue beyond age 25. You must provide medical proof of disability directly to the health plan on an annual basis for the dependent to remain enrolled.

Q19. **What dental plans will the County offer in 2012?**

A. The following dental plans will be offered

Delta Dental
Humana-OHS
MetLife DHMO

Q20. **Must I select a dental provider if I enroll in a dental plan?**

A. A dental provider selection is not required for Delta Dental You are only required to select a participating dental provider if you enroll in Humana-OHS or MetLife DHMO. You may select a participating dentist from the plan provider link included on the online menu. You may select a different participating dentist for each enrolled dependent. With Delta Dental, you may use any dental provider.

Vision

Q21. **Are there any changes to the Optix Vision Plan for 2012?**

A. No.

Q22. **Must I select a vision provider if I enroll in Optix?**

A. No. You may use any provider for out-of-network benefits or any participating provider to receive in-network benefits. The participating providers are included in the plan provider link included on the online menu.

Legal

Q23. **Are there any changes to the group legal plan for 2012?**

A. ARAG Insurance Company will continue as the legal services provider. Go to www.miamidade.gov/benefits to view the 2011 benefits enhancements.

Q24. **How do I find out what attorneys are participating in the ARAG group legal plan?**

A. The attorneys participating in the ARAG group legal plan are included in the plan provider link on the online menu.

Short Term Disability (STD)/Long Term Disability (LTD)

Q25. **Is there more than one STD Plan to choose from?**

A. Yes. MetLife offers a choice from two STD plans. The Low Option Plan pays up to 60% of your weekly with a maximum benefit of $500. The High Option Plan pays 60% of your weekly salary to a maximum benefit of $1,000.

Q26. **Are there more than one LTD Plan to choose from?**

A. Yes. MetLife offers a choice from two LTD plans. The Low Option Plan pays up to 60% of your monthly salary with a maximum benefit of $2,000. The High Option Plan pays up to 60% of your monthly salary with a maximum benefit of $4,000.

Q27. **How do I enroll for STD and/or LTD coverage?**

A. To enroll for STD and/or LTD, you must submit your selection online and complete a MetLife disability statement of health (evidence of insurability) form, which may be downloaded from the open enrollment website. The benefit will not become effective unless approved by MetLife. The completed Statement of Health (SOH form) must be mailed to:

MetLife
Statement of Health Unit
P.O. Box 14069
Lexington, KY 40512-4069

Q28. **If I am currently enrolled for the Low Option STD/LTD and wish to increase the level of coverage to the High Option STD/LTD, what must I do?**

A. To increase the level of coverage, you must submit your selection online AND complete a MetLife disability statement of health (evidence of insurability) form, which may be downloaded from the open enrollment website.

Q29. **If I am enrolled for only LTD and wish to apply for STD, will that jeopardize my LTD coverage if MetLife denies my request for STD?**

A. No. They are independent selections.

Q30. **Must I complete a statement of health if I wish to reduce the level of STD or LTD coverage (example change from the High Option Disability Plan to the Low Option Disability Plan)?**

A. A completed statement of health is not required if you reduce the level of disability coverage. You must submit your selection online and the change will be effective January 1, 2012.

Q31. **What is a pre-existing condition?**

A.

- A pre-existing condition means a sickness or accidental injury for which the employee:
- Received medical treatment, consultation, care or services; or
- Took prescription medication or had medications prescribed; or
- Had symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment

If you were diagnosed with a condition 3 months prior to enrolling or increasing coverage, MetLife will not pay for any related disability for a 12 month period after enrolling or increasing coverage.

Q32. **When will STD\LTD coverage become effective?**

A. STD and LTD benefits are effective upon approval of the medical evidence of insurability by MetLife. Coverage will be delayed if you are not in active employment status, because of injury, illness, temporary layoff or leave of absence, on the date that insurance would otherwise become effective.

Health Care Flexible Spending Account (HFSA) and Dependent Care Flexible Spending Account (DFSA)

Q33. **If I am currently enrolled for a HFSA and/or a DFSA and wish to continue for 2012, do I need to re-enroll online?**

A. Yes, you must re-enroll online to continue a HFSA or DFSA for 2012.

Q34. **What is the minimum or maximum amount I may contribute annually to a HFSA or DFSA?**

A. The annual plan minimum is $260 and the annual plan year maximum is $5000, less flex administration fees of $51.48 per year.

Q35. **Must I pay any administrative fees to participate in a spending account?**

A. If enrolling/reenrolling in a HFSA and/or DFSA, you will be payroll deducted $1.98 biweekly. If you select both accounts your total biweekly deduction will be $1.98. There are no additional administrative fees.

Health Care Flexible Spending Account (HFSA)

Q36. **Are there any changes to the Health Care Flexible Spending Account?**

A. No.

Q37. **What is the myFBMC Card®?**

A. The myFBMC Card® is a convenient Health Care Flexible Spending Account (HFSA) reimbursement option that allows FBMC to electronically reimburse eligible expenses under Miami-Dade County's plan and IRS guidelines. When you swipe the myFBMC Card® to pay for eligible expenses, funds are electronically deducted from your HFSA account. The card cannot be used for reimbursement of Dependent Care expenses.

Q38. **What are the myFBMC Card® advantages?**

A.

- Instant **reimbursements** for health care expenses, including prescriptions, co-payments and mail-order prescription services.
- Instant **approval** of known co-payments for medical and prescription drug coverage.
- Convenient, cash-less card payment for authorized co-payments and purchases.

You can also use the myFBMC Card® for certain eligible Over-the-Counter (OTC)* expenses (ex: band-aids, etc.) at drugstores.

Q39. **If I enroll in an HFSA, when will I receive the myFBMC Card®?**

A. Prior to January 1, 2012, two cards will be mailed to you (in a plain envelope); one for you and one for your spouse or eligible dependent. You should keep your cards to use each plan year you have a HFSA account until their expiration date. Only first time HFSA participants will receive the myFBMC Card in 2012.

Remember, you can go to **www.myFBMC.com** to see your account information and check for any outstanding Card transactions.

Q40. **How can I activate the myFBMC Card®?**

A. To activate your myFBMC Card® anytime visit **www.myFBMC.com**. You may also call 1-888-514-6845.

Q50. **How can I use the myFBMC Card®?**

A. After activating your card, for eligible expenses, simply swipe the myFBMC Card®. Whether at your health care provider or drugstore, the amount of your eligible expenses will be automatically deducted from your Healthcare FSA. Prescription and certain OTC* purchases with the card are only accepted at registered merchants (i.e. stores like Publix, Wal-Mart, Target and CVS). For all other qualified expenses, such as medical co-payments, the myFBMC Card® will function normally. To find out if a pharmacy near you accepts the card, please refer to the **IIAS Store List** at **www.myFBMC.com**

A complete list of Frequently Asked Questions about FSAs and the myFBMC Card® are available at **www.myFBMC.com**. If you have further questions, contact FBMC Customer Care at 1-800-342-8017 (Monday - Friday, 7 a.m. - 10 p.m. ET).

Q51. **What if the provider does not accept the myFBMC Card®?**

A. If your provider does not accept your myFBMC, or if your expense is greater than your available balance, pay for your service or purchase by cash, check or credit card. Then submit a paper claim with the appropriate accompanying documentation. Your claim will be processed and eligible expenses will be reimbursed to you by check or through direct deposit, if selected.

Q52. **How do I know if it is necessary to send documentation to FBMC?**

A. There are two ways to verify if documentation, such as an itemized claim, is required: Check your Card Transactions under the Payment Card tab on www.myFBMC.com. If you see transactions in RED, please click on the magnifying glass to determine what action is needed by you.

As a participant, you will receive a monthly statement from FBMC. Your statement will include a BLUE Outstanding Card Transactions Requiring Documentation section. If a transaction appears in this section, you must submit documentation to FBMC for your expenses. Monthly Statements can also be viewed on www.myFBMC.com.

Q53. **What happens if I fail to send in any necessary documentation?**

A. If you fail to send in the requested documentation to FBMC for a myFBMC Card® expense, you will be subject to:

Withholding of payment for an eligible paper claim to offset any outstanding myFBMC Card® transaction, Suspension of your myFBMC Card® privileges. The reporting of any outstanding myFBMC Card® transaction amounts as income on your W-2 at the end of the tax year.

Q54. **What Types of services do not require documentation?**

A. Co-payments under the Miami-Dade County health plan or prescription plan,
Mail-order prescriptions from MedCo, Multiple co-payments, Prescription & certain OTC* items purchased at IIAS certified merchants.

Q55. **What types of services require documentation?**

A. Co-payments under a spouse's Medical Plan or Prescription Drug plan
Dental expenses
Certain OTC* items
Durable medical equipment
Eyeglasses, contacts lenses or Lasik surgery

***Over-the-Counter (OTC) drugs and medicines require a prescription to qualify for FSA reimbursement and myFBMC Card use.

Q56. **How does the HFSA grace period affect myFBMC Card®?**

A. The County's HFSA allows a participant to use up any FSA funds that are left over from the previous plan year within the first 2-1/2 months (by March 15) of the new plan year. If you have funds left over from a previous plan year, you must submit any run-out paper claims from the previous plan year and ensure they have been processed BEFORE using the **myFBMC Card®**. When using the card or submitting current year paper claim reimbursements at the beginning of a new plan year, the previous year's HFSA funds will be used first to pay for your eligible expenses.